

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947
-------------------------------------------------------------	------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00126251.</p> <p>Complaint IN00126251-Substantiated. Federal deficiencies related to the allegation are cited at F 282 and F 309.</p> <p>Survey dates : May 2 and 3, 2013</p> <p>Facility number : 003691 Provider number : 155724 AIM number : 200456230</p> <p>Survey team : Michelle Hosteter, RN</p> <p>Census bed type: SNF: 35 SNF/NF: 20 Residential : 22 Total : 77</p> <p>Census payor type: Medicare : 22 Medicaid : 15 Other : 40 Total : 77</p> <p>Sample : 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
---------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Quality Review was completed by Tammy Alley RN on May 8, 2013.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/03/2013	
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the care plan for constipation was followed for 1 of 3 resident's reviewed for care plans in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>The record review for Resident B was completed on 5/2/13 at 11:15 a.m. Diagnoses included, but were not limited to, end stage Parkinson's Disease, constipation, and high blood pressure.</p> <p>A document titled "Consultation Record" dated 9/26/11, indicated, "...The patient had an incarcerated right inguinal hernia with a bowel obstruction...They understand due to his constipation and Parkinson's disease there is about a 10% chance of hernia reoccurrence...."</p> <p>The care plan dated for constipation dated 10/6/11 with a revision date of 3/15/13 indicated, "... At risk for constipation related to: decreased</p>	F000282	<p>1. MAR and BM record was reviewed for Resident B, as identified in the survey, and no adverse effects were noted. Careplan was reviewed and revised as needed.2. Reviewed careplans of residents with a diagnosis of Constipation and revised as needed. 3. Nursing staff was re-educated on the facility Bowel Protocol and careplans. Nurses will print off a "No BM in 48 hrs report" at the beginning of each shift and initiate the Bowel Protocol.4. IDT/Clinical team will monitor 5 x weekly during the morning Clinical Care Meeting through the No BM report then verifying the Elimination Circumstance form was initiated. The DHS/designee will report the findings to the QA monthly x 3 months then at least quarterly thereafter or until ongoing compliance is assured.</p>	05/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
-------------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>mobility...resident will have bowel movement at least every three days...Encourage at least 75% of meal consumption, monitor meds [medications] that may cause constipation, encourage fluids, encourage mobility and exercise, monitor bowel sounds, administer laxatives as ordered per facility policy and per family, provide fresh water at bedside, assist with fluid intake as needed, encourage to attend exercise activities...."</p> <p>The bowel records for the month of March and April 2013, indicated the resident went without a bowel movement for at least every three days on the following dates:</p> <p>March 16th, March 17th and March 18th March 23rd, March 24th and March 25th April 8th, April 9th and April 10th April 12th, April 13th, April 14th April 26th, April 27th and April 28th</p> <p>In an interview with the Health and Wellness Director on 5/3/13 at 1:15 p.m., she indicated Resident B did not receive any PRN (as needed) bowel medications during the last few months. She indicated she had provided all of the information</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
-------------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>regarding the resident's bowel care plans, records of bowel movements and documentation from nursing regarding bowels.</p> <p>3.1-35(g)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received bowel interventions to prevent constipation for 1 of 3 resident's reviewed for bowel monitoring in a sample of 3. (Resident B)</p> <p>Findings include:</p> <p>The record review for Resident B was completed on 5/2/13 at 11:15 a.m. Diagnoses included, but were not limited to, end stage Parkinson's Disease, constipation, and high blood pressure.</p> <p>A document titled "Consultation Record" dated 9/26/11, indicated, "...The patient had an incarcerated right inguinal hernia with a bowel obstruction...They understand due to his constipation and Parkinson's disease there is about a 10% chance of hernia reoccurrence...."</p> <p>The care plan dated for constipation</p>	F000309	<p>1. MAR and BM record was reviewed for Resident B, as identified in the survey, and no adverse effects were noted. Careplan was reviewed and revised as needed.2. Reviewed careplans of residents with a diagnosis of Constipation and revised as needed. 3. Nursing staff was re-educated on the facility Bowel Protocol and careplans. Nurses will print off a "No BM in 48 hrs report" at the beginning of each shift and initiate the Bowel Protocol.4. IDT/Clinical team will monitor 5 x weekly during the morning Clinical Care Meeting through the No BM report then verifying the Elimination Circumstance form was initiated. The DHS/designee will report the findings to the QA monthly x 3 months then at least quarterly thereafter or until ongoing compliance is assured.</p>	05/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
-------------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>dated 10/6/11 with a revision date of 3/15/13 indicated, "... At risk for constipation related to: decreased mobility...resident will have bowel movement at least every three days...Encourage at least 75% of meal consumption, monitor meds [medications] that may cause constipation, encourage fluids, encourage mobility and exercise, monitor bowel sounds, administer laxatives as ordered and per family policy, provide fresh water at bedside, assist with fluid intake as needed, encourage to attend exercise activities...."</p> <p>The bowel records for the month of March and April indicated the resident went without a bowel movement for at least 48 hours on the following dates:</p> <p>March 16th, March 17th and March 18th March 23rd, March 24th and March 25th March 31st and April 1st April 8th, April 9th and April 10th April 12th, April 13th, April 14th April 22nd and April 23rd April 26th, April 27th and April 28th April 30th and May 1st</p> <p>The Health and Wellness Director</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/03/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBRIDGE AVE LOGANSPORT, IN 46947
-------------------------------------------------------------	-------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>provided a document titled, "Guidelines Bowel Protocol" dated 2/14/12 and revised 6/18/12, 7/20/12, and 12/4/12. The policy indicated,"...To provide guidance for the use of bowel stimulants for residents with constipation....3. The admission order or a telephone order should be written stating "Follow Bowel Protocol" 4. The Bowel and Bladder Circumstance form shall be initiated for any resident not having a BM [bowel movement] within 48 hours (unless this has been determined to be a usual bowel pattern for this individual). a. An assessment of the abdomen shall be completed each shift that includes abdominal distention, pain and bowel sounds...."</p> <p>The nurses notes for March and April did not have any information related to constipation for Resident B.</p> <p>The physician's recapitulation for April did not have any order noted regarding following bowel protocol.</p> <p>There was no documentation on the March or April 2013 MAR (Medication Administration Record) regarding following the bowel protocol.</p> <p>There was only one ' Elimination Circumstance Form' dated, 4/15/13</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER WOODBIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 602 WOODBIDGE AVE LOGANSPORT, IN 46947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>noted in the chart.</p> <p>In an interview with the Health and Wellness Director on 5/3/13 at 1:15 p.m., she indicated Resident B did not receive any PRN (as needed) bowel medications during the last few months. She indicated the bowel protocol was not something they have used for all residents, but they would have used on someone with a history of bowel obstruction. She indicated she had provided all of the information regarding the resident's bowel care plans, records of bowel movements and documentation from nursing regarding bowels.</p> <p>3.1-37(a)</p>				